Overage Dependent Child QSC Change Form

Educational Entity Use Only	
Approved by ____	Date_____
Effective Date_______________	

If during Open Enrollment you did not enroll your Overage Dependent Child (age 19 – 25) who gained eligibility effective October 1, 2010 due to health care reform legislation, you may add them by submitting this form to your Educational Entity no later than October 29, 2010. **Any additional coverage requested using this form will be effective Oct. 1, 2010. Retroactive premiums may apply.**

Per federal health care reform, an Overage Dependent Child (age 19 – 25) is eligible to be enrolled in OEBB health plans regardless of marital, student, residency, tax **or employment status or if the dependent child has other group coverage**. Overage dependent children **who were previously ineligible for the plan, and are now eligible due to the federal provisions**, may be enrolled in the OEBB plan using this form. These dependents **will not be subject to the dental and vision 12-month waiting periods.**

1. Employee Information

Educational Entity	Employee ID, SSN, or E Number

Last Name	First Name	MI	Date of Birth	Gender ☐ M ☐ F

Contact Address ☐ Check if New Address	Apt #	City	State	Zip

Work E-mail	Personal E-mail	Work Phone	Home Phone

2. Dependent Information

Attach separate sheet if necessary.

Relationship Codes: **CH**=Employee and/or Spouse's child, **DD**=Disabled Dependent, **DP CH**=Domestic Partner's Child

Last Name	First Name	M	Birth Date (mm/dd/yyyy)	Relationship Code	Gender M	Gender F	Enroll Med	Enroll Den	Enroll Vision
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

You must report to your employer's benefits administrator within 31 days after a person enrolled as your spouse, domestic partner or dependent child becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report. If you do not report this change on time, OEBB may consider that an intentional misrepresentation of a material fact, for which OEBB may terminate the family member's coverage effective the first of the month after eligibility was lost.

3. Medical, Dental and Vision Plan Selection

Write in a plan selection for Medical, Dental & Vision. You can Opt Out of Medical or Decline any coverage.

If you **decline** Dental and/or Vision coverage when initially eligible, then you choose to enroll in one or both of these plans at a future Open Enrollment period, you and any dependents enrolled will be subject to a 12-month waiting period on these plans (meaning only preventive and routine services will be covered during the first 12 months of coverage).

Medical Benefit Plan Selection: ____________________ ☐ Opt Out of Medical* ☐ Waive Medical*

Dental Benefit Plan Selection: ______________________________ ☐ Decline Dental

Vision Benefit Plan Selection: ______________________________ ☐ Decline Vision

*To Opt Out, you must complete section 5. "Opt Out" indicates you receive a financial incentive, "waive" indicates you do not.

4. Other Group Coverage

To Opt Out of Medical coverage you must complete this section and provide proof of other group coverage to your educational entity within five business days or your opt out election will not be effective.

Plan Type:	Plan ☐ Medical	Carrier	Policy Number	Group Number
Principal Enrollee in Other Group Plan			Employer	Effective Date _ _ / _ _ / _ _ _ _

5. Medicare Coverage

Attach separate sheet if necessary. **The following individuals are covered by Medicare:**

☐ No one listed on this form is covered by Medicare.	☐ Self	☐ My Spouse or Domestic Partner Name: ___________________________ SSN/HICN:______________________	☐ A Dependent Child Name: ___________________________ SSN/HICN:______________________

6. Optional Insurance

Your Educational Entity determines which optional benefits in Section 6 it will offer and may not offer all the benefits on this form.Contact your educational entity for coverage information and to find out which benefits are available to you.

*You are required to **submit a medical history statement** on any coverage amount that is not guarantee issue.

Child or Children Optional Life Insurance ($2,000 increments, maximum $10,000)

Medical history is not required. You must enroll in employee optional life to enroll your child or children in this coverage.

New Enrollment	Change Current Coverage	Decline Coverage
Total Requested Amount: $___________	Increase to $__________ Decrease to $__________	☐

Child Optional Accidental Death and Dismemberment (AD&D)

($2,000 increments, maximum $10,000) Medical history is not required.

New Enrollment*	Change Current Coverage*	Decline Coverage
Total Requested Amount: $___________	Increase to $__________ Decrease to $__________	☐

7. Employee Signature and Authorization

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the OEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

If you fail to report on time a change that makes an enrolled family member ineligible, OEBB may consider your omission an intentional misrepresentation of a fact material to your enrollment. In that case, OEBB may terminate the family member's coverage retroactively.

This form supersedes all forms and submissions I previously made for OEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

____ ______________________

Employee Signature Date

Send this completed form to your educational entity. Do not mail this form to OEBB.